WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgement about the case.

Attach the completed Prior Authorization/Home Health Therapy Attachment (PA/HHTA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid at the address listed below. If other home health services (e.g., nursing, aide services) are being provided in addition to home health therapy services, complete this attachment form and submit it with the appropriate forms for the other services. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's ten-digit Medicaid identification number as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Therapist
Enter the name and credentials of the primary therapist who would be responsible for and participate in home health therapy services for the recipient. If the performing provider would be a certified therapy assistant, enter the name of the certified therapist who will be physically present at the residence to supervise the certified therapy assistant.

Element 5 — Therapist's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter the Medicaid provider number of the supervising therapist. *If the therapist does not have a provider and is employed by or under contract to the agency, enter the agency's Medicaid provider number.*

Element 6 — Telephone Number — Therapist
Enter the telephone number, including the area code, of the therapist who would provide the authorized service (performing provider). If the performing provider would be a therapy assistant, enter the telephone number of the supervising therapist.

Element 7 — Name — Referring / Prescribing Physician
Enter the name of the physician referring/prescribing home health therapy evaluation and/or treatment.

Element 8 — Referring / Prescribing Physician's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the physician referring/prescribing home health therapy services.

The remaining portions of this attachment are to be used to document the justification of home health therapy services.

SECTION III — DOCUMENTATION
Complete Elements 9 through 17. The provider may refer to specific sections of the attachments rather than duplicating information. For example, the provider may indicate on the attachment, "Refer to item #3 of therapy evaluation."

Element 9
Provide a brief history pertinent to the service(s) requested.

Element 10
Provide a description of the recipient's diagnosis and problems as they pertain to the need for the therapy services requested. Include the date of onset.

Element 11
State therapy history. Include type/date/location for all types of therapy.

Element 12
Indicate the date of initial evaluation. Supply dates/tests/results of additional evaluations.

Element 13
Describe progress in measurable/functional terms since treatment was initiated or last authorized.

Element 14
Attach a Plan of Care indicating specific, measurable goals and procedures to meet those goals.

Element 15
Describe rehabilitation potential.

Element 16 — Signature — Requesting Provider
Wisconsin Medicaid requires the requesting provider's signature to process the PA request. Read the Prior Authorization Statement before dating and signing the attachment.

Element 17 — Date Signed
Enter the month, day, and year the PA/HHTA was signed (in MM/DD/YYYY format).

Other Required Information

1. Attach a copy of the Physician's Plan of Care.
2. Attach a copy of the therapy evaluation.
3. If the request is for a recipient under age 22, attach a copy of the Individualized Education Program or explain why there is none.
4. If the request is for a child under age 3, attach a copy of the Individual Family Service Plan or explain why there is none.